Iowa Department of Inspections and Appeals
Health Facilities Division
Adult Services Civil Penalty Citation

Date: November 19, 2024
Program Name: Brown Deer Place
Address: 1500 1st Ave. N Coralville, IA 52241
Type of Action: 121938-A, 122166-M
Date(s) of Action: 10/7/24 to 10/17/24
Citation #: 10669

State Rule #	State Rule	Amount of Civil Penalty
67.3(9)	481-67.3 Tenant rights. All tenants have the following rights: 67.3(9) To be free from restraints. Based on interview and record review, the program failed to ensure appropriate services were provided to protect 1 of 4 tenants reviewed from being subjected to chemical restraints (Tenant #1). Findings include: 1. Review of Tenant #1's record on 10/7/24 revealed she moved into the program on 3/12/24 with diagnoses including Alzheimer's disease and severe dementia with behavioral disturbance. Her service plan, dated 4/12/24, indicated she had a severe memory impairment and was frequently disoriented. Tenant #1 had occasional behavioral issues and was known to be disruptive, aggressive or have socially inappropriate behavior. She could get very loud with staff or others when things did not go as she wanted them to. She had a history of wandering. Tenant #1's progress notes revealed the following: - on 3/13/24 the tenant yelled 911 repeatedly while being agitated and exit-seeking. - on 3/22/24 the tenant refused to shower, change clothes or sleep in her own room - on 3/25/24 it was noted the tenant refused medications over the weekend - on 4/5/24 the tenant kept asking to get in her car and leave every few minutes - on 4/12/24 she breeched the doors of the memory care unit setting off the alarms - on 4/18/24 she scratched her legs until they bled, put her bloody legs on the furniture and cussed at staff. - on 4/29/24 the tenant was yelling at staff and going into others' apartments near midnight. 2. A review of an internal investigation dated 7/12/24 revealed on 7/8/24 at 11:30 AM, Staff B informed the former Health Care Coordinator (HCC) Staff A potentially gave Tenant #1 a higher dose of her scheduled liquid Risperidone than was ordered. Staff B saw Staff A come out of the medication room with something in her hand, which she threw in the trash. Staff B walked to the trash and looked for the item and saw Tenant #1's empty bottle of Risperidone. On 7/9/24 at 11:30 AM, the Executive Director and HCC interviewed Staff	**$2000.00**

	A who said she did not want to deal with Tenant #1's behaviors, but had since stopped giving the tenant extra medication. Staff A was suspended on 7/9/24 pending the conclusion of the investigation. The HCC completed a physical assessment and Tenant #1's vital signs were stable. She was more sleepy than normal over the weekend but back to normal on 7/10/24. The Regional Nurse Specialist wrote in the internal investigation she spoke with a representative of the pharmacy and learned the pharmacy dispensed 30 ml bottles of Risperidone on 4/19/24, 5/3/24, 5/17/24, 5/29/24, 6/11/24, 6/24/24, 7/1/24 and 7/5/24 (240 ml total). A review of Tenant #1's Medication Administration Record (MAR) from 4/19/24 - 7/9/24 revealed a total of 105 ml's should have been administered to Tenant #1. The Risperidone bottle dispensed on 7/5/24 could not be located. The bottle filled on 7/1/24 had approximately 25 ml's left. There were approximately 90 ml's of Risperidone which were unaccounted for. Staff A admitted to giving Tenant #1 more Risperidone than prescribed by her Primary Care Provider (PCP) when interviewed, according to the internal investigation, but said she stopped doing this as of 7/6/24. Staff interviewed revealed staff had no suspicions this was occurring until 7/6/24. 3. A review of Tenant #1's MAR for May, 2024 revealed she received 0.5 ml of Risperidone twice daily (at noon and 8:00 PM) from 5/1/24 to 5/3/24. Beginning on 5/4/24, Tenant #1 received 0.5 ML of Risperidone three times daily (noon, 2:00 PM and 8:00 PM). One bottle of medication should have lasted approximately 20 days. The Risperidone was filled more frequently than every 20 days. A visit note from Tenant #1's Primary Care Provider (PCP) on 6/14/24 noted at that time she was becoming quite drowsy during the day. The program nurse was not sure the PCP should change the Risperidone to a pill form to be certain Tenant #1 was getting the correct amount of medication. Review of a police report narrative dated 9/27/24 revealed on 9/13/24 at 1:00 PM, Staff A stated she was dealing with an extra physical and mental load at work. She slowly gave Tenant #1 an increasing dose of Risperidone to manage her behaviors. She administered higher doses when Tenant #1 did not appear to be harmed. 4. On 10/16/24 at 9:45 AM, the former HCC reported she only worked for the program for about 1.5 months. During her time working there, she heard from the staff Tenant #1 was lethargic and not herself. She working with Tenant #1's PCP to get lab work to try and determine the cause of the lethargy. Tenant #1 would be more lively in the morning but sedated in the afternoon. Staff A often worked in the afternoon. Tenant #1 was able to be roused and her vitals were fine but they could not determine what was wrong with her. She stated she kept getting notifications from the pharmacy they were getting requests to refill the Risperidone too early but she did not inquire more deeply into	

	this because she was often being sent off to other buildings and could not focus on tenant care. When interviewed on 10/8/24 at 10:45 AM, Staff B reported she walked into the medication room on 7/6/24 in the afternoon and saw Staff A drawing up a syringe of Risperidone for Tenant #1 all the way full (3 MLs - six times the prescribed dose). It would not have been appropriate to prepare medication in the afternoon for the 8:00 PM dose of medication. Staff B confronted Staff A about the amount of medication in the syringe and she believed Staff A emptied the excess medication into the bottle. Staff B asked Staff A to report this to the nurse but this did not happen. Staff B did not immediately notify the HCC or Executive Director. She recalled the night before (7/5/24), she overheard Tenant #1 tell Staff A she did not like her medication because it made her feel very wobbly and like she could barely walk. Staff B did not notice the Risperidone causing this side effect to Tenant #1 when she administered the medication. On 10/8/24 at 1:33 PM, Staff C reported seeing a syringe of Risperidone on 7/6/24 for Tenant #1 with too much medication in it. She was also aware each time she worked with Staff A, the employee administered the tenant's 8:00 PM medication at dinnertime (4:30 PM - 5:00 PM). More than once, Staff C heard Staff A say something about giving Tenant #1 medicine to put her to sleep. Staff C recalled during this period Tenant #1 was sleeping more. People wondered what was wrong as the tenant was not asking questions like she normally did. Some of the co-worker's thought it was because Staff A was giving her more medication. Staff C declined to name the co-workers, saying she could not remember their names. During an interview on 10/8/24 at 2:05 PM, Staff D reported she saw Staff A give Tenant #1 syringes with 0.5 ML, 1.0 ML or more Risperidone at dinnertime. Other employees also gave Tenant #1 Risperidone at dinnertime rather than at 8:00 PM. On 10/9/24 at 10:45 AM, the Executive Director and Regional Nurse Specialist confirmed these findings.	
67.2(3)	481—67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. 67.2(3) The program shall follow the policies and procedures established by the program. Based on interviews and record review, program staff failed to follow the program's policy on Medication and Medication Administration and the policy on Adult Abuse Reporting for 1 of 4 tenants reviewed (Tenant 1). Findings include: Review on 10/7/24 of an internal investigation completed by the program identified an incident on 7/6/24 in which Staff A admitted to giving Tenant #1 more of the medication, Risperidone, then	

	prescribed, but stated she stopped doing this as of 7/6/24. Interviews with other staff revealed they reportedly did not have any knowledge of this occurring until Staff B had suspicions of such practices on 7/6/24. A review of physician's orders for Tenant #1 dated 7/15/24 revealed she was to receive 0.5 ML of Risperidone Solution 1 mg/ML three times daily, beginning on 5/3/24. Tenant #1 was to get the medication at 8:00 AM, noon and 8:00 PM. On 10/8/24 at 10:45 AM Staff B stated she witnessed Staff A drawing a syringe of Risperidone on 7/6/24 with too much medication in it. She then observed Staff A with a medication bottle in her hand which she appeared to try and hide by keeping her arms folded. Staff B said she asked Staff A if she had given Tenant #1 the medication as Staff B was aware the medication should not be administered until 8:00 PM. Staff A stated she was getting it ready for later. Staff B then witnessed Staff A discard the medication bottle in the trash. Staff A dug out the discarded bottle from the trash and confirmed the medication bottle was for Tenant #1. Staff B then asked another staff (Staff C) if Staff A usually drew up the medication early and Staff C confirmed it was common for Staff A to prepare medication early and administer the medication at dinner time instead of the prescribed time of 8 PM. Staff B then went into the kitchen and discovered Staff A had left the pre-filled full syringe in the unlocked kitchen cabinet. Staff B stated she confronted Staff A about the incorrect dosage and stated she instructed Staff A to call the nurse and inform the nurse of the error. Staff B stated she did not notify the nurse of the error until Monday, 7/8/24. When interviewed on 10/8/24 at 1:30 PM Staff C stated she observed the pre-filled syringe for Tenant #1 and knew it contained more than the prescribed amount of Risperidone. Staff C was aware Staff A generally pre-filled the syringes and would keep them in the community kitchen cabinet until dinner but was unsure whether Tenant #1 received more than the prescribed amount on other dates. Staff C recalled Staff A said things such as she should give Tenant #1 more medicine to put her to sleep. Tenant #1 was sleeping more during this time. Her co-workers questioned if this was because Staff A was giving Tenant #1 more medicine. Staff C did not provide any names of the co-workers. Staff C did not report any of these concerns to the Health Care Coordinator (HCC) or the Executive Director. On 10/8/24 at 2:05 PM Staff D stated she was aware Tenant #1 was ordered to receive Risperidone at 8 AM, noon, and 8 PM but a lot of staff, including Staff A, were giving it to Tenant #1 at suppertime because the tenant didn't like to take it at bedtime. Staff put it in her coffee at supper. Staff D further stated she occasionally observed different dosages in the syringe; sometimes observing it at .5 ml and other times observing it at 1 ml which she believed was the maximum amount the syringe could hold. Staff D stated she was unaware of the amount of Risperidone Tenant 1 was supposed to receive so never reported it to anyone. There were times Staff D witnessed Staff A get aggravated with the tenant. In her opinion, Staff A got out of hand.	

	She was unable to provide specific examples, but believed Staff A should have walked away from the tenants sooner than she did. Staff D did not report her concerns regarding Staff A to anyone. On 10/16/24 at 2:03 PM, Staff E reported Staff A got easily annoyed with Tenant #1. Staff A got in Tenant #1's face, tried to demean her and tried to instill fear in her. She confirmed Tenant #1 was hard of hearing, but denied Staff A was only trying to make herself heard. Staff E did not put her concerns in writing, but believed she spoke with the former Health Care Coordinator about her concerns. A review of the program's policy entitled Medication and Medication Administration instructed staff to consistently follow the six "Rights" for proper and accurate administration of medicines and included (but not limited to) the following steps: #2. Right dose - Always be sure that you are giving the prescribed amount of medication. Too much may be dangerous, too little maybe ineffective. #3. Right time - Specific timing may be important for certain drugs to be most effective. If a certain time is specified for the medication, it needs to be given only at that time. The policy further educated staff: Perhaps the most important concept about the "Six Rights" is that a violation of any right constitutes a medication administration error. Thus, if any mistake is made, it should be reported immediately to the on-call nurse so counter measures to solve any resulting problems can be taken. A medication error report form must also be completed and submitted to the RN on-call. On 10/8/24 review of the program's policy entitled Adult Abuse Reporting included the following staff instructions: "If you suspect a dependent adult has been abused, you must report it to the Director or Nurse immediately," and "The employee who witnesses or becomes aware of abuse or suspects abuse should immediately notify the person in charge." On 10/8/24 at 3:26 PM the Regional Nurse Specialist stated staff should have called the nurse on-call on 7/6/24 per policy instead of completing a nurse communication sheet or waiting until the following Monday to verbally report the misuse of the medication and suspicion of abuse. On 10/9/24 at 10:45 AM the Executive Director confirmed the above findings.	